cent. strength, though in the later cases formaldehyde of English manufacture was employed. The fluid was vigorously rubbed in with a largish brush or mop for ten minutes, the hair having been shaved round the margin of the patches. The application was repeated every other day on four occasions and then entirely discontinued. In some patients the head was painted every day for four successive days. Of the 40 cases only 5 required repainting from non-eradication of the disease, and in these the fault lay not with the remedy, but in the fact that, owing to the struggles of the child, no proper application could be made. The ages of the children treated ranged from 4 to 12, and the extent of the disease varied from a small strictly localised patch to areas which were practically co-extensive with the whole scalp. Microscopical examination was always made before commencing the treatment, and the actual presence of the trichophyton verified, whilst before pronouncing any case cured microscopical examination was again made. In 38 of the cases the fungus presented the characters of trichophyton microsporon.

Formalin thus applied induces discomfort and irritation of very brief duration rather than actual pain, and does not vesicate the scalp as it does the skin elsewhere. Only 3 cases showed any suppuration after its use, and in these the process was slight, and did not destroy any of the follicles. It produces, however, a thick crust, just as weaker solutions cause desquamation upon the skin of the arm, and the subsequent application of some emollient is advisable to accelerate the removal of this exudation. Growth of healthy hair commences immediately, and in three or four weeks the denuded patch is covered with hairs $\frac{1}{8}$ in. long.

Before concluding, allusion must be made to a remarkable occasional complication of the treatment. In 6 cases œdema of the face was noted some hours after the painting. In one boy this was so extensive as to completely prevent vision from swelling of the eyelids, and the forehead pitted $\frac{1}{2}$ in. on pressure. The skin, however, was neither hot nor red, and there was no pain or constitutional disturbance. The œdema only occurred when the area treated was very large, and the condition is probably analogous to that produced by a nettle sting on a big scale.

It is interesting in this connection to remember that the active toxic agent in the nettle is formic acid, and that it is thus closely related to the substance now under discussion. The occurrence of this œdema renders it advisable either to deal with limited areas at a time, or to warn the parents of the possible result if the whole scalp is to be attempted at once.

A NOTE ON PICRIC ACID IN THE TREATMENT OF SUPERFICIAL BURNS AND SCALDS.

BY D'ARCY POWER, M.B., F.R.C.S.ENG.,
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THE treatment of superficial burns and scalds has long seemed to be most unsatisfactory, for these injuries are attended with an unnecessary amount of inflammation, whilst the act of renewing the dressings is unduly painful. From time to time I have tried various methods of treatment, and I have come to the conclusion that the picric acid treatment is by far the simplest and the most satisfactory. The method is well known in France, where it has been extensively used by Professor Thièry, whilst Dr. Filleul and Dr. Papazoglou have done their best to disseminate a knowledge of its value. I do not therefore claim the least merit for myself, but I find that so few practitioners know of it that is perhaps worth while to draw attention to it in England.

The solution of picric acid is made by dissolving a drachm and a-half of picric acid in 3 ounces of alcohol, which is then diluted with two pints of distilled water, or more accurately: Picric acid, 5 g.; alcohol, 80 g.; dissolve; add 1.000 g. of distilled water. This is a saturated solution of picric acid.

The clothing over the injured part should be gently removed, and the burnt or scalded portion should be cleaned as thoroughly as possible with a piece of absorbent cotton wool soaked in the lotion. Blisters should be pricked, and the serum should be allowed to escape, care being taken not to destroy the epithelial surfaces. Strips of sterilised gauze are then soaked in the solution of picric acid, and are so applied as to cover the whole of the injured surface. A thin layer of absorbent cotton wool is put over the gauze, and the dressing is kept in place by a light linen bandage. The moist dressing soon dries, and it may be left in place for three or four days. It must then be changed, the gauze being thoroughly well moistened with the picric acid solution, for it adheres very closely to the skin. The second dressing is applied in exactly the same manner as the first, and it may be left on for a week.

The great advantages of this method of treatment are: First, that the picric acid seems to deaden the sense of pain; and, secondly, that it limits the tendency to suppuration, for it coagulates the albuminous exudations, and healing takes place under a scab consisting of epithelial cells hardened by picric acid. A smooth and supple cicatrix remains, which is as much superior to the ordinary scar from a burn as our present surgical scar is superior to that obtained by our predecessors, who allowed their wounds to granulate.

I have used this method for more than a year in hospital practice both amongst out-patients and in-patients, and I have every reason to be thoroughly satisfied with the results I have obtained. It is not an ideal method, for it stains the clothes and discolours the hands of the surgeon, but it is a great improvement upon anything else I know of.

CEREBRAL HÆMORRHAGE DUE TO WHOOPING-COUGH.

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THE case of facial paralysis occurring in a patient with whooping-cough, which was recorded by Dr. Craig in the BRITISH MEDICAL JOURNAL of June 13th, recalls to my mind a somewhat similar instance which came under my observation some time ago.

I. L., aged 5¾, was first seen on March 29th, 1893. For over three weeks she had been suffering from an attack of whooping-cough of moderate severity. For nearly two weeks she had been troubled with occasional attacks of headache and earache, at times very severe. These attacks were attributed to injuries of the face and head sustained in falling downstairs a few days before.

On the afternoon of March 28th she came in complaining of headache and severe sickness. When put to bed, she vomited once. During the night she became worse, and was said to be stupid, and at times unconscious. Next morning I found her apathetic and partially comatose; irritable when interfered with. There was right hemiplegia, paralysis of the arm being absolute, of the leg incomplete. The head was turned slightly towards the right. The pupils were normal and equal, reacting slowly to light. The pulse was regular, 96; the temperature 98.2°. The heart sounds were normal. There were no indications in personal or family history of a tuberculous disposition or of syphilis.

I expressed the opinion that the condition was the result of a hæmorrhage due to the strain imposed on the cerebral vessels by the paroxysms of coughing.

On March 30th the coma had increased, but she could still be roused. The pulse was 114, the temperature 101°. Two or three times during the night she had emitted a cephalic cry. During the evening and night there were repeated right unilateral convulsions, said to begin in the thumb and then to pass on to the arm and leg. Each attack lasted 3 to 5 minutes.

On the morning of March 31st coma was complete; the head was turned more to the right, the face looking over the right shoulder. It was not rigid, but always reassumed the oblique position. The pupils were normal, but reacted very slowly. The temperature was normal; pulse 98, unequal and retarded. During the night the convulsions continued to recur, and when seen on April 1st, with Dr. Riddell, the general condition was unchanged. The child had a convulsion. The movements began in the right thumb, were confined to it for a few seconds, and then passed rapidly in suc-